

one of the Los Angeles daily papers. Wherein lies the fault? With the courts, for permitting this defiance to the court to go unchallenged or with the paper that publishes the advertisement of a convicted violator. Certainly the Board of Medical Examiners have done their work well in convicting said individual of violating the state law.

A convicted violator who appeals from the judgment of conviction has the same legal status as one who has *not* been found guilty.

It will not be amiss in this article to explain the status of a licentiate whose license has been revoked. Neither professional men nor laymen can comprehend how any legal action against the Board for a review or similar action, grants to said licentiate the right to go serenely on with his practice as though no action had been taken against him.

The individual, whose license has been revoked, has recourse in the Superior Court to a Writ of Review or Certiorari, usually accompanied by a Restraining Order served on the Board, which suspends the Board's order of revocation or any other activities in relation to the particular case. During the pendency of a writ, the "hands" of the Board are tied, the petitioner can practice "right merrily," and the Board can take no action:

- (a) to stop said licentiate based on the revocation;
- (b) to serve the County Clerk with a notice of revocation;
- (c) to leave the petitioner's name out of the Directory;
- (d) to refuse acceptance of the annual tax;
- (e) to take any steps which in any way would reflect on the petitioner's standing as a legalized practitioner in the State of California.

After the Superior Court has reviewed the findings of the Board, an appeal is made to the Supreme Court, which refers the case back to the Appellate Court for an opinion. If the opinion be unfavorable to the appellant, a rehearing is requested. If said rehearing is denied, an appeal is filed with the Supreme Court.

If the Supreme Court sustains the action of the Board, the case is closed. However, should the action of the Board be reversed, the losing party may again ask for a rehearing, this time in the Supreme Court.

It does not require any very keen perception, after reviewing these various steps, to determine why these cases drag through a period of from two to three years before a final decision has been reached.

The vote of the people on medical and public health matters, as recorded on November 2, 1920, is an encouraging indication that the public still has faith in scientific medicine, and is a further indication that the medical profession has awakened from its lethargy to the full realization of the tremendous latent power that can be aroused by organization, exercising well directed effort. Legislators as well as municipal officers have often stated that the medical profession has

not as yet awakened to the realization of its latent power, but when once aroused to concerted action, its power of accomplishment is limitless.

Let us summarize the avenues open to accomplishments by *concerted action*:

- (1) Exercise of legislative contact in your home district.
- (2) Exercise of personal contact with the editorial staff of the newspapers published in your community to:
 - (a) discourage acceptance of advertisements of individuals who are violating the law;
 - (b) to change the policy adopted by many papers that paid advertising insures editorial support regardless of the merit or truth of statements in said advertisements;
 - (c) to grant the courtesy of reply in their columns to any article printed therein, which willfully misrepresents, or has a tendency to imply the existence of conditions in relation to scientific education, public health or law enforcement unfounded on fact.
- (3) Personal contact with the law enforcement machinery of your community that it may be impressed with the justice of your plead for:
 - (a) More expeditious disposition of cases involving violation of the Medical Practice Act.
 - (b) Closer scrutiny in the selection of prospective jurymen.
- (4) Personal contact with the public, both individually and collectively, disseminating the truths regarding public health measures, prophylaxis, preventive medicine, medical education and regulation.

The foes are legion that seek to destroy the safeguards to public health, erected by scientific medicine after years of heroic struggle. The attack is not only local, but has assumed a nation-wide well-financed campaign.

What will the harvest be?

The answer lies with **YOU**.

Original Articles

THE PRESENT NURSING SITUATION.*

By W. W. ROBLEE, M. D., Riverside.

During the past half century the practice of medicine under the stimulus of such epochal development as has come through the great discoveries of bacteriology, pathology, chemistry, pharmacology, physics and the other branches of true science, has undergone a complete metamorphosis. No longer can the untrained herb doctor or bone setter visit a sick person, feel his pulse, look at his tongue, and after dispensing some empirical mixture of herbs or mineral compound or "set" a supposedly dislocated or broken bone, depart with a consciousness of having done any real service to his patient.

* Read before the Forty-ninth Annual Meeting of the Medical Society of the State of California, Santa Barbara, May, 1920.

Neither can the modern physician who has been trained in the laboratory and clinic, with all the aids of the science and art of modern practice do well by his patients without lay assistance. The greatest of these aids is the thoroughly trained nurse. Anything which in any way influences the nursing profession for good or ill reacts directly upon the physician, and should be his concern.

We have not only grown to depend upon the trained nurse for the care of patients in hospital, but we have been educating the public to ask for nursing service in the home, and to use these women for much of the detail work in the great public health and social betterment movements in practically every community. This furnishes an outlet for the energy and enthusiasm of the best type of young womanhood along lines of personal and social service for which women are pre-eminently fitted.

We older men who have been privileged to watch the development of this noble group of women, have been tremendously impressed with their value and usefulness and have counted it a privilege to have had some part in it.

Like many other great social movements, problems of policy arise about which there are honest differences of opinion as between the parties concerned. Just at this time some problems are pressing for solution, and it will be profitable for us to consider them most carefully. There are three parties involved:

First. The Public whom we serve.

Second. The Nurse who renders the service.

Third. The Physician, who by training and legal responsibility, is employed to and held responsible for the care of the sick.

Any action taken or laws put upon the statute books which do not take all three parties into consideration are essentially unjust, and therefore to be condemned. The aim of this paper is to call attention to some fundamental facts, abuses and dangers in the present situation in order that if possible the three interested parties may get together and work for a constructive program which shall be just to all.

The public (1) not only needs, but has been taught to value expert nursing service.

(2) The wealthy and very poor classes are now able to secure such service. The one, completely because of financial ability to pay the other to quite an extent through municipal and relief organizations and public hospitals.

(3) The great middle class of wage earners (except for certain skilled classes) salaried employees, certain professional men and women and others of moderate income find it impossible to pay for nursing service at the present rate of compensation expected by the graduate nurse.

Sickness in such families means either real or fancied failure to secure adequate care, a burden of expense which spells a ruinous debt or the sacrifice of the necessities of life on the part of others in the family.

For instance a recent case of pneumonia and empyema which, under the twelve-hour rule, required two nurses, entailed an expense amounting

to over six hundred dollars for nurse hire, in addition to which was the cost of feeding them.

Nurse hire, like the cost of other necessities, is rising higher and higher, and Mr. Average Citizen cannot buy all he needs or desires.

The Nurse.

1. Has seen the requirements for her training raised from year to year and the time of training lengthened, until now as much is required of her in time and effort as is necessary to practice medicine by way of the osteopathic route or to become a teacher or social worker, and far more than is asked of commercial employees.

2. Has also seen the cost of living mount to proportions that require an augmented income to support herself.

3. She has seen the legal hours of labor lowered by law for her sister workers in other occupations, while hers have continued to be long and arduous.

4. No one can gainsay these facts or object to her compensation adequate for time consumed in preparation for her profession and to meet the high cost of living, nor can we wonder at her desire for easier hours and better working conditions.

5. She has in times past been shamefully exploited by certain hospitals and training schools, both as to length of service, daily hours and character of labor performed.

The Physician. Is interested

1. In preserving in the highest state of efficiency and usefulness this most helpful of all his therapeutic aids. The two must work hand in hand. Any antagonism or lack of full co-operation as between the two professions must be avoided.

The influenza epidemic, as was to be expected, found the supply of nurses and trained attendants woefully inadequate. No plan could supply enough trained nurses for such an emergency, and it would not be desirable that such a supply should be trained, but certainly auxiliary sources of supply should be, and can be, developed.

The Superintendent of the State Nurses' Bureau tells me that 85% of women trained in that profession leave bedside nursing, either private or hospital, within three years. Many are married, others become dietitians, teachers, public health and social workers, doctors' office assistants, hospital administrators, etc. This wastage, the increase in population, and more general appreciation of nurses' service, renders it absolutely necessary that a constant influx of pupil nurses shall be maintained.

Last year in this state about 100 fewer young women applied for training than was the case during the two preceding years. Superintendents of training schools report increasing difficulty in securing pupils for their schools. This is due (1) to the high wages paid in many of the unskilled industries. (2) To the general prosperity of the country, because of which it is unnecessary for so many women to be self-supporting. (3) To the length of time, three years demanded

for training, and the higher educational requirements now in force.

The problem briefly stated is this:

The public having been taught the value of the nurse finds itself very frequently deprived of such service by reason of prohibitive expense. In time of epidemic there are not sufficient nurses to begin to meet the problem. The nurses are striving to better their professional standing, they are asking for sufficient remuneration to cover their long years of training, their wastage of time while waiting for cases, and the increased personal expense due to the mounting cost of living, and for reasonable working hours.

The doctor is the buffer between these two; he must keep both patient and nurse satisfied. What is the answer?

1. How secure an adequate supply of pupil nurses.

In my opinion the training course should be reduced from three years to two for bedside nurses. This has been done in several states, notably Illinois. Any girl can be taught adequate bedside nursing in two years *if the time is given to nursing*. Pupil nurses should be largely relieved of such menial labor as scrubbing floors, toilets, care of bed pans, etc., which can be handled by unskilled laborers hired for that purpose. The so-called eight-hour law which is in reality less than a seven-hour law, should be made a straight eight-hour law. It now requires three and one-half student nurses per twenty-four hours to special a case. There should be a sufficient number of student nurses in the hospital so that they can do more of the special duty work, thus relieving the graduate nurse for private work.

The preliminary educational requirement should be based upon a grammar school, and not a high school diploma, thus allowing many earnest young women who have not been able to support themselves through a high school course to enter training.

Those who expect to qualify for institutional or public health service should be required to take an additional year of advanced training.

The nurses' curriculum should be modified, and the teaching staff in each training school visited by an official of the state board who shall carefully explain the scope of the course and the type of teaching desired.

The present curriculum is too elaborate. There is no profit in making a nurse a poorly instructed doctor. For instance, take the subject of chemistry. It is absolutely without profit to teach a nurse anything beyond simple urinalysis and a few chemical principles useful in dietetics. The care of the patient should be stressed, first aid carefully taught, and a birdseye view of the body and its functions outlined. Beyond this is without profit, and the student had much better be employed specializing an actual sick person or playing tennis for her health's sake.

Some states, including California, are trying out a plan of educating a group of young women as trained attendants. The course lasts one year, and a license to care for the sick is given upon com-

pletion of the course. So far only one hospital in this state has taken advantage of this law.

In principle, I am opposed to the establishment of classes in the nursing profession. We will always have the old "practical nurse"—she is known as such, and fills a certain useful position—but if the state licenses a woman to care for the sick, it will be very difficult for the public to differentiate as between classes. I think that it is far better to adopt a sensible minimum course, and license but one class. Our educational institutions, newspapers and platforms should be used to impress upon young women the opportunities for service offered by the nurses' profession. There might be a nurses' week possibly, in connection with some other problem, such as the tuberculosis fight when the claims of the profession could be impressed upon the public. Many young people drift until something tangible is brought to their attention.

Nurse wastage can be materially reduced. Many of the nurses now employed in doctors' offices where they are giving but a fraction of their time to their professional work, should be released for bedside service. A doctor who really has the best interest of his patients at heart will reduce his office nurse force to the lowest possible minimum. Auxiliary positions, such as dietitians, supervisors of unskilled labor, etc., should not be filled by graduate nurses. Sociological workers should not be recruited from the nursing profession. Much can be done by careful consideration of the element of wastage in the profession.

Great care should be exercised in the framing of legislation limiting the hours of nursing duty. The present forty-eight hour law for pupil nurses is in need of revision upward to a fifty-six hour basis. The agitation either for a twelve-hour law for graduate nurses, or a limitation by a trades union agreement is wrong. Each case is to be considered on its merits. Many require but nominal care, and a nurse has plenty of time for rest in a twenty-four hour tour. A twelve-hour shift in the average home obstetrical case would place the service beyond the reach of most of our citizens. The care of mother and baby does not overtax a nurse.

Patients requiring constant care, and those entailing great physical or nerve strain, cannot and should not, in justice to either nurse or patient be handled on a twenty-four hour shift. This should rightly be a matter of adjustment as between the parties concerned, and the physicians should see to it that the nurse secures sufficient rest.

Trades' Union methods, such as have been adopted by a certain group of nurses in Los Angeles recently, whereby a twelve-hour shift for all patients under their care was ushered in by a strike, by picketing, threats of violence, etc., can have no place in any scheme for handling this problem, and where found should be condemned and fought to a finish.

How can Mr. Average Citizen's problem be solved? Should the nurse be asked to lower her

fees and bear the portion that Mr. Citizen is unable to bear?

No. The nurse is getting none too much for her work if she is to live decently and save something.

Two plans suggest themselves to me:

1. Some plan should be evolved whereby hourly nursing service can be made available. Most patients need less attention than we have taught our nurses to give. There is too much temperature taking, bathing, rubbing, charting and general fussing about a patient. How often do we hear a patient say "oh, just let me alone."

If a nurse could come in once a day, give a bath, change the bed, give an enema, or make the personal toilet, the need would be well met. The balance of necessary attention could be given by the unskilled people in the home.

The Victorian Order of Canada solves that problem splendidly, and is a tremendous success. If the Red Cross or a new organization could be made to stand sponsor for such a plan it would meet a real need. I am not now speaking for the very poor, they are already furnished a great deal of such service in many communities. I am advocating an organization in each community which shall have the backing of a strong committee. This organization would hire the nurses needed, pay them a good salary, these to be available for service to the average self-respecting citizens of moderate income. It would be a big step toward solving the problem.

2. There should be a systematic effort made to instruct at least one person in every home as to the simpler essentials of the care of the sick.

What a comfort it is to go into a home and have some woman hand you a little piece of paper with some temperature records thereon and to see the patient's person, bed and sick-room neat and tidy.

This society should back the Red Cross or other organizations in their home-nursing programs, and if necessary the county society and local nurses should give short courses in a few essentials. The slogan should be "at least one person in every home who can take a temperature, give a bath or enema, make a bed and prepare a simple invalid's meal."

The most important point I want to urge is that there must be harmony and co-operation between all the elements to this problem. No law should be placed upon the statute books, no rule adopted which materially changes the status of any party to the problem until all have an opportunity to be heard.

A PLEA FOR BETTER FRACTURE RESULTS.*

By GEO. J. McCHESNEY, M. D., San Francisco.

In no branch of surgery have we learned more from our war experience than in the treatment of fractures, and now is the time to apply that dearly-bought knowledge before it becomes a dim memory.

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The war fractures—practically all open and a large percentage comminuted—were hence of the most difficult type, and quite the reverse of the civil variety. So, speaking from experience, after handling the war type of fracture, the civil seems almost ridiculously easy when the same principles are applied, and the treatment of fresh fractures thus becomes a real pleasure and not a flurried attempt to obtain some sort of union, dismiss the patient, and avoid a lawsuit.

What in brief are the principles emphasized by the war treatment of fresh fractures:

(1) That the traction method of treating fractures, now nearly perfected, should be used much oftener.

(2) That meticulous or geometric accuracy of approximation is not necessary for good function.

(3) That metallic fixation or internal splinting is never absolutely necessary.

(4) That as a consequence, operations are needed much less than is the practice at present.

In discussing these points in detail, the first and greatest lesson concerning the renaissance of the traction method, is the recognition of the importance and value of the Thomas traction splint and its various modifications and accessories. Being simple in design and operation, it is both easy to make and to apply. By taking its counter-pressure against the tuberosity of the ischium or against the shoulder, it does not fasten the patient to one spot in the bed, as does the weight and pulley form of traction. On the contrary, the patient can be quite comfortably transported from bed to wheelchair or from place to place if needed. The use of the bedpan is made easier, and the patient can be put into the sitting position to avoid pneumonia.

Second. By allowing the injured limb to be always open to inspection and massage, it does away with the principal drawback of plaster of Paris, which may easily hide a beginning sepsis as well as an angulation at site of fracture.

Third. By changing the tension in the supporting slings thus raising or lowering the fragments, antero posterior defects in alignment can be corrected, and by the use of screw-pressure pads, clamped to the side bars, lateral deviations can be corrected. Thus we have a direct pull to overcome the shortening tendency from muscle-spasm, and also means of making correction thrusts at right angles, in any direction, on either fragment, surely an ideal arrangement.

Fourth. Dressings can be done much more easily, especially if large ones, and the spread of infection watched and guarded against better than with plaster splints.

Another great advance is in the early mobilization of neighboring joints, especially the knee and elbow joints. Not only can they be inspected and massaged daily but flexion bars can be attached to the sides of the Thomas splint and slight motions at the joint made daily, while the fracture is still efficiently splinted. This does away completely with the stiff knees especially, that have retarded for six months or a year the complete convalescence of fractured femurs. The same